MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

122110

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ALICE (Middle) MAY (Last) BERKENBAUGH

4. DATE OF DEATH: (Month) March (Day) 17 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-13-1901

9. AGE last birthday: 48 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hayman

14. MOTHER'S MAIDEN NAME: Ida Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Mrs. Robert Diehl

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

171 Immediate cause (a) Uremic Pois.

172a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of cervix c

(c) metastasis to kidneys, liver, etc

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1948, to 17 Mar, 1949, that I last saw the deceased alive on 17 Mar, 1949, and that death occurred at 12.45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John B. Davis, MD ADDRESS Frostburg, Md DATE SIGNED 3/17/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: 3/19/49 NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-18-49 REGISTRAR'S SIGNATURE Mrs Laney N. Roe

24. FUNERAL DIRECTOR: J. R. Durst ADDRESS Frostburg Md

VS. A15

RECEIVED
MAR 21 1949
BUREAU V. S.

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
LENGTH OF STAY (In this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Penna. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.D.# 3 Cumberland
STREET ADDRESS (If rural, give location) Near Koon Dam ✓

3. NAME OF DECEASED (Type or Print) (First) Baby Boy [redacted] (Middle) (Last) Blubaugh

4. DATE OF DEATH (Month) Mar. (Day) 13, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 3-13-1949

9. AGE last birthday yrs. | If under 1 year Months. | Days | If under 24 hrs. Hours | Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Eldren Fritz

14. MOTHER'S MAIDEN NAME Dorothy Rosalie Blubaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT Rosalie Blubaugh - Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776 **Immediate cause** (a) Prematurity

159 **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 13 March, 1949, to 13 March, 1949, that I last saw the deceased alive on 13 March, 1949, and that death occurred at 3:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Leland B. Lawson MD ADDRESS 63 Greene St. Cumb. Md. DATE SIGNED 14 March 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 3-15-1949

NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. March 14, 1949

REGISTRAR'S SIGNATURE Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

Dr. P.R. Wilson
02202

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (in this place): 27 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miller St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): Miller St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Marie (Last) Campbell

4. DATE OF DEATH: (Month) March (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 8, 1873

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own-Home

11. BIRTHPLACE (State or foreign country): Allegany, Maryland

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: George Schramm

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XXXX (If year, give war or dates of service): XXXXX

16. SOCIAL SECURITY No.: XXXXXX

17. INFORMANT: Aden Campbell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage - Hemiplegia and other Paralysis. — Interval Between Onset and Death: 1 Day

Antecedent cause(s)

530 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 15 Years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): —

(COUNTY): —

(STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐: —

HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from Mar 10, 1946, to Mar 24, 1949, that I last saw the deceased alive on Mar 23, 1949, and that death occurred at 9:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Paul R Wilson MD

ADDRESS: Piedmont, W. Va

DATE SIGNED: Mar. 26, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: March 27 49

NAME OF CEMETERY OR CREMATORY: Philos

LOCATION (City, town, or county) (State): Westernport Md.

DATE REC'D BY LOCAL REG.: Mar. 26/49

REGISTRAR'S SIGNATURE: [illegible] Baginbaker M.D.

24. FUNERAL DIRECTOR: Ellsworth S. Boal

ADDRESS: Westernport, Md.

RECEIVED
MAR 28 1949
BUREAU V. S.

Within corporate limits

02203

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 50 Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 238 Williams Street	STREET ADDRESS (If rural, give location) 238 Williams Street

3. NAME OF DECEASED (Type or Print)	(First) Annie	(Middle) Elizabeth	(Last) Conner	4. DATE OF DEATH	(Month) March (Day) 5 (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH March 15 1872	9. AGE last birthday 76 yrs.	If under 1 year Months 11 Days 20; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House	10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) Piney Plaines, Maryland	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Joseph Conner		14. MOTHER'S MAIDEN NAME June Golden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT Grant A. Conner			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

290.0 Immediate cause (a) Pernicious Anemia — 10 yrs

73a) Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1940, to March 5, 1949, that I last saw the deceased alive on 3 4, 1949, and that death occurred at 8 30/9 m., from the causes and on the date stated above.

SIGNATURE H W Eliason Md. (Degree or title) ADDRESS 126 Nmonth Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 8 1949	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	LOCATION (City, town, or county) Cumberland (State) Maryland
DATE REC'D BY LOCAL REG. March 7, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight	ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02204

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 40, about 1/2 way between Locust Grove & Mt. Savage Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
STREET ADDRESS (If rural, give location) Homewood Addition

3. NAME OF DECEASED (Type or Print) (First) Howard (Middle) Hubby (Last) Crosten

4. DATE OF DEATH (Month) March (Day) 1 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH May. 6-1910
9. AGE last birthday 38 yrs. If under Months. 1 year Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelley Springfield
10b. KIND OF BUSINESS OR INDUSTRY Building Tires
11. BIRTHPLACE (State or foreign country) Mt Rose W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Crosten 236-14-6177
14. MOTHER'S MAIDEN NAME Mary Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 236-14-6177
17. INFORMANT Wolford Funeral Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 Immediate cause (a) Intracranial hemorrhage & shock due to a crushed skull & broken neck.

170c Antecedent cause(s) (b) Hit by an automobile, while walking on highway.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH: at once

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Auto. accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Route 40 near (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) March 1 (Day) -/49 (Year) 1.30 A.m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Hit by an auto. while walking on highway

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ March 1, 1949, ~~to~~ ---------, ~~19~~ --, that I last saw the deceased ~~alive~~ Dead on 3-1-, 1949, and that death occurred at 1.30 A.m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED March 1-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3/3/49
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Cumberland, Allegany, Md.

DATE REC'D BY LOCAL REG. March 3, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John E. Wolford ADDRESS Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 8 1949
BUREAU V. S.

Within corporate limits

Evidence for change of father's name on:

FILM No. G 120 MAY -6 1949

02205

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 14 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone
STREET ADDRESS (If rural give location) Route 2.

3. NAME OF DECEASED (Type or Print) (First) Rose (Middle) Mary (Last) Dolly

4. DATE OF DEATH (Month) Mar (Day) 13 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Dec 26, 1948

9. AGE last birthday yrs. If under 1 year Months 2 Days 19 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Roy Dave ~~Earl A.~~ Dolly

14. MOTHER'S MAIDEN NAME Mary Elizabeth Barnett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Earl A. Dolly

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) acute laryngotracheobronchitis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) malnutrition

474
106c

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 12 1949, to March 13, 1949, that I last saw the deceased alive on 3/12, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Elie Brong (Degree or title) M.D. ADDRESS La Vale, Md. DATE SIGNED 3/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Mar 15 1949

NAME OF CEMETERY OR CREMATORY Dolly Cemetery

LOCATION (City, town, or county) Flintstone (State) Md.

DATE REC'D BY LOCAL REG. March 15, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR John J. Hofer ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits

DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

02206

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) Queen City Hotel

3. NAME OF DECEASED (Type or Print): (First) EVA (Middle) (Last) DURBIN
4. DATE OF DEATH: (Month) MARCH (Day) 13 (Year) 1949

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: DEC. 11, 1894
9. AGE last birthday: 54 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Bolt Forge Restaurant
11. BIRTHPLACE (State or foreign country): Gaithersburg md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN DURBIN
14. MOTHER'S MAIDEN NAME: MARY JANE NORRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 210-14-6648
17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

592 Immediate cause (a) Pneumonia — 2 days

1310 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr Nephritis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Cumberland Alley (CITY OR TOWN) Md (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6/49, 19..., to 3/13/49, 19..., that I last saw the deceased alive on 3/13/49, 19..., and that death occurred at 3:30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Williams MD — ADDRESS Cumberland Md — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 3/16/49 — NAME OF CEMETERY OR CREMATORY Hillcrest Cem. — LOCATION (City, town, or county) Cumberland, md (State)

DATE REC'D BY LOCAL REG. March 15, 1949 — REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR James F. Scarpelli — ADDRESS Cumberland md

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

02207

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING,
STREET ADDRESS (If rural, give location) ROUTE #1, BOX #4,

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) E. (Last) DYE

4. DATE OF DEATH: (Month) MAR. (Day) 22, (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: SEPT. 3, 1876

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN CLARK

14. MOTHER'S MAIDEN NAME: MARY PLATTER Platter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebro Vascular Accident — Interval Between Onset and Death: 3 days

260

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

61

(b) Hypertension

(c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1949, to 3/22, 1949, that I last saw the deceased alive on 3/22, 1949, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M. Simons M.D. 128 Union St. Cumberland, Md

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Mar. 24, 1949 | NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery | LOCATION (City, town, or county) (State): Lonaconing, Maryland

DATE REC'D BY LOCAL REG.: March 24, 1949 | REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR: M. Eichhorn, | ADDRESS: "

RECEIVED
MAR 29 1949
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

02208

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Spring Gap
LENGTH OF STAY (in this place): 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: PENNA. — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyndman, PA RD#1.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Benjamin	Joseph	Emerick		3	4	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	6-8-1888	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Coal Miner	Coal Mines	Hyndman, Pa.	Usa

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Solomon E. Emerick	Mary E. Emerick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	War I	170-18-1395	Virgil L. Emerick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
151 Immediate cause	(a) Carcinoma Stomach	2 yrs.
468 Antecedent cause(s)	(b) —	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cirrhosis Liver	8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
NO				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan 15, 1949, to 3-4, 1949, that I last saw the deceased alive on 3/14, 1949, and that death occurred at 9 a m., from the causes and on the date stated above.

SIGNATURE: John A Tepper. (Degree or title) — ADDRESS — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3/7/49	Hyndman, Pa.	Hyndman, Pa.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 6, 1949	Winter R. Brant M.D.	Harry H. Tepper.	Hyndman, Pa.

RECEIVED
MAR 15 1949
BUREAU V. S.

Within corporate limits

02209

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shallmar
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED (Type or Print) (First) ~~Baby~~ ALLEN RAY (Middle) ~~Boy~~ (Last) Evans			4. DATE OF DEATH (Month) Mar (Day) 19 (Year) 1949		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: Mar 18 1949	9. AGE last birthday: yrs.	If under 1 year: Months / Days 1 — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Shallmar, Garrett Maryland		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Earl Martin Evans			14. MOTHER'S MAIDEN NAME: Emma Loo Paugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.: None	17. INFORMANT: Miss Mildred Sharpless		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

773.0 Immediate cause (a) unknown

158 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) baby was brought into the hospital in respiratory failure, moribund

(c) ~~By the time~~ orders were given by telephone X

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. newborn

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 19....., to —, 19....., that I last saw the deceased alive on —, 19....., and that death occurred at 7 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Eliz. Brings, M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Mar 21 1949	NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery	LOCATION (City, town, or county) (State): Elk Garden, W. Va.
DATE REC'D BY LOCAL REG.: March 21, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: Otha F. Sharpless	ADDRESS: Blaine, W. Va.

X At the time of my arrival baby had expired

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02210

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 15 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Loartown, Frostburg, Md.
STREET ADDRESS (If rural, give location): R. D. No. I Box 348

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Frances (Last) Fatkin

4. DATE OF DEATH: (Month) 3 (Day) 2 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 6-1898

9. AGE last birthday: 50 yrs. If under 1 year: Months 6, Days 26; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Loartown, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jacob I. Blubaugh

14. MOTHER'S MAIDEN NAME: Lizzie Lageer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John Fatkin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4222 Immediate cause (a) Chr Myocarditis — Interval Between Onset and Death: 5 Years

938 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, 19..., to Mar 2, 1949, that I last saw the deceased alive on Mar 2, 1949, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W O'M Lane M.D. ADDRESS: Frostburg Md DATE SIGNED: 3-2-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 3-5-49 NAME OF CEMETERY OR CREMATORY: Vale Summit Cem. LOCATION (City, town, or county) (State): Vale Summit, Md.

DATE REC'D BY LOCAL REG. 3-5-49 REGISTRAR'S SIGNATURE: Mrs. Nancy N. Ross

24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md.

RECEIVED
MAR 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02211 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (In this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carlos-Frostburg, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) SAMUEL (Middle) J. (Last) FILER

4. DATE OF DEATH: (Month) March (Day) 6, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 4-11-77

9. AGE last birthday: 71 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. A. Filer

14. MOTHER'S MAIDEN NAME: Frances Prichard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-3594

17. INFORMANT: Samuel Filer, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

199.1 **Immediate cause** (a) Sarcoma Right Thigh — 6 mo

55e **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1948, to Mar 6, 1949, that I last saw the deceased alive on Mar 3, 1949, and that death occurred at 4:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

W M McLane M D — Frostburg Md — Mar 9 1949

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE: Mar. 9 '49 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 3-9-49 | REGISTRAR'S SIGNATURE: Mrs. Daisy A. Rae

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

RECEIVED
MAR 14 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02212

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 25 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 618 Montgomery Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 618 Montgomery Ave

3. NAME OF DECEASED (Type or Print): (First) Francis (Middle) Sigel (Last) Fleming

4. DATE OF DEATH: (Month) March (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: December 9 1872

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Central Y.M.C.A.

11. BIRTHPLACE (State or foreign country): Simpson, W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James B. Fleming

14. MOTHER'S MAIDEN NAME: Mary E. Moose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Lulu L. Fleming

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334 Immediate cause (a) Cerebro Vascular Accident — Interval between onset and death: 4 hrs.

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Cumberland (CITY OR TOWN) Allegany (COUNTY) Md (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/6, 19.4.9, to 3/20, 19.4.9, that I last saw the deceased alive on 3/20/49, 19....., and that death occurred at 5:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): George M Symons M.D. — ADDRESS: 124 Union St Cumb. Md. — DATE SIGNED: 3/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Mar 24,1949 — NAME OF CEMETERY OR CREMATORY: Simpson Baptist Cemetery — LOCATION (City, town, or county) (State): Simpson, W. Va.

DATE RECD BY LOCAL REG.: March 22,1949 — REGISTRAR'S SIGNATURE: Winter R. Stantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

RECEIVED
MAR 29 1949
BUREAU V. S.

Within corporate limits

02213

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 28 ½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Grantsville
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) Glen (Middle) Creed (Last) Folk
4. DATE OF DEATH (Month) 3 (Day) 27 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 2/21/48
9. AGE last birthday 1 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Glen D. Folk
14. MOTHER'S MAIDEN NAME Annabelle Long
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT Glenn D. Folk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

754.4 Immediate cause (a) Virus Pneumonia — 7 days.

1572 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congenital Heart.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cretinism

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2.26, 1949, to 3.27, 1949, that I last saw the deceased alive on 3.27, 1949, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE R. W. Eleason (Degree or title) Me. ADDRESS 126 Mount St Cumberland DATE SIGNED Mar 27

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF March 29-49 NAME OF CEMETERY OR CREMATORY Maple Glenn LOCATION (City, town, or county) R D 1 - Fort Hill (State) Somerset Md

DATE REC'D BY LOCAL REG. March 28, 1949 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Wm Winterberg - Grantsville ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

Within corporate limits DR. TOLSON F. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02214

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: OAKLAND
STREET ADDRESS (If rural give location): STAR ROUTE

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CLARENCE	WILSON	FRAKER	MARCH	2,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	MAY 15, 1878	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MINISTER		MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES FRAKER	ROSIE SPECH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	None	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Broncho Pneumonia	4 days.
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocardial Degeneration	
	(c) Generalized Arteriosclerosis.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-26, 1949, to 3-2, 1949; that I last saw the deceased alive on 3-1, 1949, and that death occurred at 2:40 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams	M.D.	Cumberland.	3/2/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 6 1949	Flatwoods	McHenry, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 3, 1949	Wroten R. Frantz, M.D.	O. F. Sharpless,	Blaine, W. Va.

RECEIVED
MAR 8 1949
BUREAU V. S.

Outside of City limits

MARYLAND STATE DEPARTMENT OF HEALTH

02215

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY: Allegany — STATE: MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland — LENGTH OF STAY (In this place): 75yrs. HOSPITAL OR INSTITUTION OR STREET ADDRESS: Christie Road, R.F.D. #2	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. — COUNTY: Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Cumberland STREET ADDRESS (If rural, give location): Christie Road, R.F.D. #2

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Mark	E.	Free		March	22	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Jan. 13-1874	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
B&O.R.Ry laborer	Railroad	Cumberland Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaac Free	Melvinea Lentz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	705-05-8531	son) H.Free 25 Boone St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-vascular-renal disease	several
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis, nephritis & arteriosclerosis	years
	(c)	

442
13(a)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

Deputy Medical Examiner (Allegany Co.)

22. I hereby certify that I attended the deceased from 3-22, 1949 to ---------, 19---, that I last saw the deceased alive on 3.22, 1949, and that death occurred at 6.40 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V.Deming M.D.		Cumberland Md.	March 22-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 25 1949	Greenmount Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 24, 1949	Winter K. Dantz M.D. Deputy Medical Examiner - Allegany Co.	James Scarpelli,	" "

RECEIVED
MAR 29 1949
BUREAU V. S.

Within corporate limits

02216

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 2 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 520 Baltimore Ave.	STREET ADDRESS (If rural give location): 520 Baltimore Ave.

3. NAME OF DECEASED (Type or Print) (First) Nathan	(Middle) David	(Last) Friedland	4. DATE OF DEATH (Month) March	(Day) 16	(Year) 1949
5. SEX: male	6. COLOR OR RACE: white (Jewish)	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: June 27-1894	9. AGE last birthday: 54 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cumberland Laundry (owner)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Houtzdale Pa,	12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME: Bernard Friedland			14. MOTHER'S MAIDEN NAME: Jennie Brenner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): War 1-Navy	16. SOCIAL SECURITY NO.		17. INFORMANT: Berill Friedland		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Myocardial failure due to marked coronary — 2 hours

96 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) sclerosis, also had a bilateral hydrothorax (moderate)

(c) & a large aortic aneurysm.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 3-16, 1949, ~~to~~ ----------, 19--, that I last saw the deceased Dead ~~alive~~ on 3-16, 1949, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE: H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS: Cumberland Md. DATE SIGNED: March 16- 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 3-18-49	NAME OF CEMETERY OR CREMATORY: Roosevelt Cemetery	LOCATION (City, town, or county) (State): Philadelphia Pa.
DATE REC'D BY LOCAL REG.: March 16, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md	ADDRESS

Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02217

CERTIFICATE OF DEATH

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage | LENGTH OF STAY (In this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cemetery Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) Cemetery Road

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) LEWIS (Last) GEARY

4. DATE OF DEATH: (Month) March (Day) 4, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3-4-07

9. AGE last birthday: 42 yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager & clerk

10b. KIND OF BUSINESS OR INDUSTRY: grocery store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Geary

14. MOTHER'S MAIDEN NAME: Cora Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: 215-10-2285

17. INFORMANT: Mrs. John Geary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcenoma of Stomach — 10 mo.

Antecedent cause(s) (b) Cachexia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

151
46b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Generalized abdominal metastases

19a. DATE OF OPERATION: July 10, 1947

19b. MAJOR FINDINGS OF OPERATION: Carcinoma - Stomach

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 11, 1948, to Mar. 4, 1949, that I last saw the deceased alive on March 4, 1949, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James P. Vaccinaro M.D. — ADDRESS Mt. Savage, Md. — DATE SIGNED 3/5/49

23. BURIAL, CREMATION, REMOVAL (Specify): burial — DATE: 3-7-49 — NAME OF CEMETERY OR CREMATORY: Methodist Cemtery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG. 3-6-49 — REGISTRAR'S SIGNATURE: Vernica McDermitt

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
MAR 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02218

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (In this place): all her life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 70 Water St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 70 Water St.

3. NAME OF DECEASED (Type or Print): (First) JULIA (Middle) LAPP (Last) GEIS

4. DATE OF DEATH: (Month) Mar. (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 10-13-56

9. AGE last birthday: 92 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Conrad Lapp

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Haberlein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Chris Koegel

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 **Immediate cause** (a) Arterio Sclerosis — Years

97 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19..., to Mar 1, 1949, that I last saw the deceased alive on Jan 26, 1949, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm Lane MD — ADDRESS: Frostburg Md — DATE SIGNED: 9-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar. 3 '49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-3-49 — REGISTRAR'S SIGNATURE: Mrs. Harvey A. Lee

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

RECEIVED
MAR 5 1949
BUREAU V. S

Within corporate limits

02219

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1907 Bedford Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. Va. COUNTY Randolph
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkins
STREET ADDRESS (If rural give location) 120 Central Ave

3. NAME OF DECEASED (Type or Print) (First) CALEB (Middle) HARTZELL (Last) GODWIN

4. DATE OF DEATH (Month) March (Day) 31 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Feb. 15, 1890
9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker
10b. KIND OF BUSINESS OR INDUSTRY Wm. Md. R. R.
11. BIRTHPLACE (State or foreign country) Be lington, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robert Godwin
14. MOTHER'S MAIDEN NAME Alice Poling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uoknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-10-8301
17. INFORMANT Mrs. Frank Heinze

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Failure	36 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	10 yrs
	(c)	

4222
93d

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25/49, 19....., to 3/31/49, 19....., that I last saw the deceased alive on 3/31/49, 19....., and that death occurred at 6 am m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] ADDRESS Cumberland Md DATE SIGNED 3/31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 3 1949
NAME OF CEMETERY OR CREMATORY Maplewood Cemetery
LOCATION (City, town, or county) Elkins, W. Va. (State)

DATE REC'D BY LOCAL REG. March 31, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John W. Lohr ADDRESS Elkins, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

Within corporate limits

02220

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 313 Greene Street

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY (Last) GRIFFIN
4. DATE OF DEATH (Month) March (Day) 27, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Mar. 27, 1949
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dennis Ambrose Griffin
14. MOTHER'S MAIDEN NAME Ruth Marlee Denny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Ambrose Griffin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Traumatic Delivery, Previable Prematurity — 35 minutes

761.5

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Premature rupture of Membanes (6 wks), Shoulder presentation

160C

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 March 1949, to 27 March 1949, that I last saw the deceased alive on 27 March, 1949, and that death occurred at 3:42 PM m., from the causes and on the date stated above.

SIGNATURE Leland S Ranson MD (Degree or title) ADDRESS 63 Greene St Cumberland Md DATE SIGNED 28 March 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Mar. 28, 1949
NAME OF CEMETERY OR CREMATORY St. Patrick's
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG. Mar. 28, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS Louis Stein, Inc., Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

Within corporate limits

02221

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

EVIDENCE FOR CHANGE OF BIRTH DATE IS ON:

FILM No. G 119 MAR 22 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS III W. Second St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) III W Second St.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) W. (Last) Hansel

4. DATE OF DEATH (Month) March (Day) 6, (Year) 1949

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Dec 15, ~~1871~~ 1871
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Grocerman
11. BIRTHPLACE (State or foreign country) Frostburg, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph P. Hansel
14. MOTHER'S MAIDEN NAME Mary Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 212-12-8614
17. INFORMANT Mrs James V. Wagoner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio-Vascular — 5 yrs.

(c) Disease

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1949, to Mar. 6, 1949, that I last saw the deceased alive on Mar. 5, 1949, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

SIGNATURE Clay E. Burrett (Degree or title) M. D. ADDRESS Cumberland DATE SIGNED 3/7/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3/8/49
NAME OF CEMETERY OR CREMATORY Rose Hill
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. March 7, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

RECEIVED
MAR 15 1949
BUREAU V. S.

Dr. Davis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

012229 Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type or use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) LILLY (Middle) (Last) JACKSON

4. DATE OF DEATH: (Month) March (Day) 10 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 2-2-1949

9. AGE last birthday yrs. If under 1 year: Months 1 Days 7 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Norman Jackson

14. MOTHER'S MAIDEN NAME: Dorothy McKee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Norman Jackson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) atelectasis c lobar Pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

760
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2-'49, to 10 Mar, 19 49, that I last saw the deceased alive on 10 Mar, 19 49, and that death occurred at 605 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, MD Frostburg, Md 3/10/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3-11-1949
NAME OF CEMETERY OR CREMATORY: Allegany Cemetery
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-11-49
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Lee

24. FUNERAL DIRECTOR: J. R. Durst,
ADDRESS: Frostburg, Md.

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02223

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 47 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 92 W. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 92 W. Main St.

3. NAME OF DECEASED (Type or Print): (First) Leora (Middle) (Last) Jenkins

4. DATE OF DEATH: (Month) 3 (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: 3-16-1879

9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Richard Hatfield

14. MOTHER'S MAIDEN NAME: Caroline Burkefolder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Blanche Jenkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) advanced arteriosclerosis

(c) Diabetes, Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

060
61

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Dec, 1948, to 3-12, 1949, that I last saw the deceased alive on 3-12, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, MD Frostburg, Md 3/14/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 3-15-1949

NAME OF CEMETERY OR CREMATORY: Allegany

LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REG. 3-14-49

REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: John Hafer

ADDRESS: Frostburg Md

RECEIVED
MAR 17 1949
BUREAU V. S.

02224

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 26 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 126 W. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 126 West Main Street

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Mary (Last) Joyce
4. DATE OF DEATH (Month) 3 (Day) 7th (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb. 2, 1870
9. AGE last birthday 79 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Martin Donahue
14. MOTHER'S MAIDEN NAME Mary Carroll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT William Joyce

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	48 hours
Antecedent cause(s)	(b) Hypertension & Arteriosclerosis	10 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2, 1949, to 3/7, 1949, that I last saw the deceased alive on 3/7, 1949, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE W E Gattens (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 3/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3/10/49.
NAME OF CEMETERY OR CREMATORY ST. Michael's
LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 3-9-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS 23 E. Main St. Frostburg

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 14 1949
BUREAU V. S.

Within corporate limits

Dr. Richard Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

112225

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 48 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 228 Utah Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 228 Utah Ave.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Karns

4. DATE OF DEATH: (Month) March (Day) 17 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 1, 1863

9. AGE last birthday: 86 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired teamster

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Bedford Co., Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Karns

14. MOTHER'S MAIDEN NAME: Rebecca Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Nancy Karns

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 **Immediate cause** (a) Chr Myocarditis — Interval between onset and death: 10 yrs

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15/49, 19....., to 3/17/49, 19....., that I last saw the deceased alive on 3/15/49, 19....., and that death occurred at 2:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS Cumberland Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: March 20, 1949 — NAME OF CEMETERY OR CREMATORY: Fairview Christian Cemetery — LOCATION (City, town, or county) Bedford Co. (State) Pa.

DATE REC'D BY LOCAL REG.: March 19, 1949 — REGISTRAR'S SIGNATURE: Winter R. Beanty, M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Md.

RECEIVED
MAR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02226

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport, ; STREET ADDRESS (If rural, give location) 300 Maryland Avenue.

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Anne (Last) Kelly.

4. DATE OF DEATH: (Month) March (Day) 28, (Year) 1949.

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 26, 1866.

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Wheeling, West Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Thomas Garrity.

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Loretto Kelly.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.2 Immediate cause	(a) Pulmonary Edema and Ileus	One Day
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Subacute Cholecystitis and Cholangitis	3 Days
	(c) Chronic Myocarditis and Myocardial Degeneration, Not specified as rheumatic	1 Year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) — (COUNTY) — (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — — — —

INJURY OCCURRED While at Work ☐ Not While At work ☐: —

HOW DID INJURY OCCUR? — —

22. I hereby certify that I attended the deceased from March 25, 1949, to March 28, 1949, that I last saw the deceased alive on Mar 28, 1949, and that death occurred at 2:25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul A Wilson M.D. Piedmont, W. Va. Mar 29 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: March 31, 1949. | NAME OF CEMETERY OR CREMATORY: St. Peters | LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: Mar. 29/49 | REGISTRAR'S SIGNATURE: Registrar MD

24. FUNERAL DIRECTOR ADDRESS: Wm Harold Friedlock Jr. Piedmont, W. Va.

RECEIVED
APR 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12227 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (In this place) 40yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.
STREET ADDRESS (If rural, give location) 16 5 th. St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) M. (Last) Kesecker Sr.
4. DATE OF DEATH: (Month) March (Day) 3 (Year) 49

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 6, 1884
9. AGE last birthday: 64 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: B&O R R
11. BIRTHPLACE (State or foreign country): Morgan County W.Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter L. Kesecker
14. MOTHER'S MAIDEN NAME: Mary Slivers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT: Edna Kesecker, I6 5th St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
33d Immediate cause	(a) Pyelonephritis	6 days
83d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause etating the underlying cause last	(b)	
	(c) Cerebral palsy	10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditione contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1949, to Mar. 3, 1949, that I last saw the deceased alive on Mar. 2, 1949, and that death occurred at 12 30 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur F. Jones M.D. 110 S. Centre St. Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: March 6, 49
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.
LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: March 4, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli
ADDRESS: Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

George Kesecker Sr.

RECEIVED
MAR 8 1949
BUREAU V. S.

Within corporate limits

02228

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

C

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1.1/2 Hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Springfield
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Janet (Middle) Kay (Last) Kesner

4. DATE OF DEATH (Month) March (Day) 3 (Year) 1949

5. SEX Female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH Dec. 29-1948

9. AGE last birthday 0 yrs. If under 1 year: Months 2, Days 4; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Springfield W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Glenn A Kesner

14. MOTHER'S MAIDEN NAME Thelma Crabtree

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
570.0 Immediate cause	(a) Aspiration of stomach contents	about 2
122b Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Intussusception of small intestine 2 places	days
	(c) also had dilatation of the stomach.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Mar. 3, 1949, to ~~10~~, that I last saw the deceased ~~alive on~~ Dead Mar. 3, 1949, and that death occurred at 6.15 P.m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED March 3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE March 4, 1949 NAME OF CEMETERY OR CREMATORY Greenspring LOCATION (City, town, or county) Greenspring, W.Va. (State)

DATE REC'D BY LOCAL REG. March 3, 1949 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. 24. FUNERAL DIRECTOR U.C. Kuckman, ADDRESS Romney, W.Va.

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

RECEIVED
MAR 8 1949
BUREAU V. S.

(corrected)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02229

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): about 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: West Virginia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near) Springfield
STREET ADDRESS (If rural, give location): R.F.D.#1 Star Route ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Marvin	A.	Kimble	March	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	June 6-1905	43 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Celanese Corp. of Am.	Rayon	Davis W.Va.	U.S.A.

13. FATHER'S NAME: James L.Kimble

14. MOTHER'S MAIDEN NAME: Mintie Snider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	217-10-5356	Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intracranial hemorrhage due to a (suspected) self inflicted wound through frontal bone into brain, from a 22 caliber (long) revolver	about 4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

976
164C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT ? SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
suspected	House of Fort Ashby	2 miles Fort Ashby		W.Va.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
3-3-49 about 11 a.m.	A	Found in a pickup truck with bullet wound in forehead. revolver in truck.

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ saw the deceased from 3-7- ....., 19 49, to ---------, 19---; that I last saw the deceased alive on 3-7- ....., 1949, and that death occurred at 4.15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	3-7-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 9, 1949	Davis	Davis, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 8, 1949	Walter R. Frantz - per T		

Deputy Medical Examiner - Allegany Co.

VS. A15

MAR 30 1949

Within corporate limits Durrette

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02230

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 50 South St.

3. NAME OF DECEASED (Type or Print) (First) Raymond (Middle) Joseph (Last) Kline

4. DATE OF DEATH (Month) March (Day) 8 (Year) 1949

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 27, 1891
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker welder
10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad
11. BIRTHPLACE (State or foreign country) Paw Paw, W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles E. Kline
14. MOTHER'S MAIDEN NAME Sarah Dolan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 705-14-0553
17. INFORMANT Mrs Raymond J. Kline

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Haemorrhage	3 hrs
83a	Antecedent cause(s)		
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	6 mos
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 8, 1949, to Mar 8, 1949, that I last saw the deceased alive on Mar 8, 1949 and that death occurred at 4:15 A m., from the causes and on the date stated above.

SIGNATURE Clay E. Lurrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 3/8/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 3/10/49
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. March 10, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz. M.D.
24. FUNERAL DIRECTOR John J Hafer ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

Within corporate limits DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02231

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 15 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA, COUNTY HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OKONOKO
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) DAVID (Middle) ROGER (Last) LEASE

4. DATE OF DEATH (Month) MARCH (Day) 29 (Year) 1949

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) CHILD

8. DATE OF BIRTH 1946 NOVEMBER, 18

9. AGE last birthday 2 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HAROLD F. LEASE

14. MOTHER'S MAIDEN NAME ALICE G. SIPES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemorrhagic purpura — INTERVAL BETWEEN ONSET AND DEATH 2 days

493 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pneumonia — 3 wks.

109 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-14-, 1949, to 3-29, 1949, that I last saw the deceased alive on 3-29, 1949, and that death occurred at 10:10 P.m., from the causes and on the date stated above.

SIGNATURE D. G. Grove M.D. (Degree or title) ADDRESS Cumberland, Maryland DATE SIGNED 3-29-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 4-1-49

NAME OF CEMETERY OR CREMATORY Bethel Cemetery

LOCATION (City, town, or county) Hampshire County, (State) Va

DATE REC'D BY LOCAL REG. March 31, 1949

REGISTRAR'S SIGNATURE Winter R Trantz, M.D.

24. FUNERAL DIRECTOR John T Wolford ADDRESS Cumberland Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02232

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport; LENGTH OF STAY (In this place) 18 Yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 Waverly St. MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport; STREET ADDRESS (If rural, give location) 108 Waverly St

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Nicholas (Last) Leatherman

4. DATE OF DEATH: (Month) Mar. (Day) 12 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 27, 1858

9. AGE last birthday: 91 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): West. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not. Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 0

17. INFORMANT: Mrs. Victor Liller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 Immediate cause (a) Chr. Cardio-Vascular-renal

1310 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15, 19 49, to 3/12, 19 49, that I last saw the deceased alive on 3/11, 19 49, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R W Reese M D Westernport Md 3/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 3/14/49; NAME OF CEMETERY OR CREMATORY: Old Pine; LOCATION (City, town, or county) (State): Hampshire County-W. Va

DATE REC'D BY LOCAL REG. Mar. 16 1949; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Ellsworth S. Boal ADDRESS: Westernport

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02233

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ELLEN (Middle) (Last) LEE

4. DATE OF DEATH: (Month) March (Day) 24, (Year) 19 49

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed

8. DATE OF BIRTH: 6-15-1853

9. AGE last birthday: 95 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Patterson

14. MOTHER'S MAIDEN NAME: Esther Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Esther Lee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

475 Immediate cause (a) Bronchopneumonia, Terminal

107 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Upper respiratory Infection

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 2/mor, 19 49, to 2 4/mor, 19 49, that I last saw the deceased alive on 2 4/mor, 19 49, and that death occurred at 11 30A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, M.D. Frostburg, Md. 3/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 3/28/49 | NAME OF CEMETERY OR CREMATORY St. Michael's Cemtery | LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 3-27-49 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

VS. A15

MAR 29 1949
BUREAU U. S.

Within corporate limits

Durrette

112234

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 221 South St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 221 South St.

3. NAME OF DECEASED (Type or Print): (First) Aaron (Middle) Jonathan (Last) Logue

4. DATE OF DEATH: (Month) March (Day) 14 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 16, 1873

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B & O Railroad

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hezekiah Logue

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Carrie Logue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1 **Immediate cause** (a) Coronary Thrombosis — Interval between onset and death: Sudde

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis — Interval between onset and death: 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 19 49 to Mar. 14, 19 49, that I last saw the deceased alive on Mar. 14, 19 49, and that death occurred at 6:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Geo. F. Lewis M.D. Cumberland 3/16/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: March 17, 1949 | NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery | LOCATION (City, town, or county): Hyndman, Pa. (State)

DATE REC'D BY LOCAL REG.: March 17, 1949 | REGISTRAR'S SIGNATURE: Winston K. Beauty, M.D. | 24. FUNERAL DIRECTOR: John J. Hafer | ADDRESS: Cumberland, Md.

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits

02235

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Queen City Pavement

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 16 Queen City Pavement

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) L. (Last) Lopresto

4. DATE OF DEATH (Month) March (Day) 14 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH July 26-1901

9. AGE last birthday 47 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker

10b. KIND OF BUSINESS OR INDUSTRY Shoerepair

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME Joseph R. Lopresto

14. MOTHER'S MAIDEN NAME Catherine Franco

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 220-16-5870

17. INFORMANT James F. Scarpelli

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar pneumonia (right lung) — INTERVAL BETWEEN ONSET AND DEATH about 1 week

490 Antecedent cause(s)

108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. empyema

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 3-14, 1949, ~~to~~ ---------, ~~19--~~, that I last saw the deceased ~~alive~~ Dead on 3-14, 1949, and that death occurred at 11.20P m., from the causes and on the date stated above.

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED 3-15-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE March 19, 1949 NAME OF CEMETERY OR CREMATORY Mt. Carmel Pittsburg, Pa. LOCATION (City, town, or county) Pittsburg, Pa. (State)

DATE REC'D BY LOCAL REG. March 16, 1949 REGISTRAR'S SIGNATURE Wruter R. Krantz, M.D. 24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

Deputy Medical Examiner - Allegany C

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02236

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 10 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 227 CECELIA STREET

3. NAME OF DECEASED (Type or Print)	(First) EDNA	(Middle) PEARL	(Last) MANGOLD	4. DATE OF DEATH (Month) MARCH	(Day) 27 (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APR. 16, 1886	9. AGE last birthday 62 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Keyser West Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME W. H. FREELAND		14. MOTHER'S MAIDEN NAME MARY LAMB			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

584 Immediate cause (a) Acute Pancreatitis Ruptured 3 27, 3/14

126 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) I think the entire Pancreas.

(c) Was diseased, Gall stones

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic Infection

19a. DATE OF OPERATION 3-17, 49 — 19b. MAJOR FINDINGS OF OPERATION Ruptured Diffusing at necrosis pancreas — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1949, to 3-27, 1949, that I last saw the deceased alive on 3-27, 1949 and that death occurred at 3/27 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) A H Hawkins — ADDRESS — DATE SIGNED 3/28 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF March 30/49	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Cumberland (State) Md.
DATE REC'D BY LOCAL REG. March 30, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF BIRTH DATE IS ON:
FILM No. G 119 MAR 22 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02237

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing | LENGTH OF STAY (in this place): 7 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural give location): 15 Washington St.

3. NAME OF DECEASED (Type or Print): (First) Venie (Middle) Isabell (Last) McGee

4. DATE OF DEATH: (Month) Mar (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 8, 1875

9. AGE last birthday: 74 yrs. | If under 1 year: Months 0 Days 6 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own-Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph N. Micheal

14. MOTHER'S MAIDEN NAME: Catherine Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XXX | (If yes, give war or dates of service): XXX

16. SOCIAL SECURITY No.:

17. INFORMANT: James G. McGee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Congestive Heart Failure

630 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic - Hypertensive disease with Hyperthyroidism

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..., to 3/3, 1949, that I last saw the deceased alive on 3/3, 1949, and that death occurred at 5-30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Paul Eugene Frye, M.D. | Lonaconing Md. | 3/3/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: March 6 1949 | NAME OF CEMETERY OR CREMATORY: Old Coney | LOCATION (City, town, or county): Lonaconing | (State): Maryland

DATE REC'D BY LOCAL REG.: March 5 1949 | REGISTRAR'S SIGNATURE: Jannette M Boal

24. FUNERAL DIRECTOR: Ellsworth S. Boal | ADDRESS: Westernport Md.

RECEIVED
MAR 14 1949
BUREAU V. S.

Within corporate limits

02238

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1454

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr. Eliason

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 25 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 326 Beall Street	STREET ADDRESS (If rural give location) 326 Beall Street

3. NAME OF DECEASED (Type or Print) (First) JANE (Middle) (Last) McKENTY			4. DATE OF DEATH (Month) March (Day) 7 (Year) 1949		
5. SEX Female	6. COLOR OR RACE Wjite	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 14, 1874	9. AGE last birthday 74 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Nelson			14. MOTHER'S MAIDEN NAME Flora Sinclair		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	17. INFORMANT Mrs. Gerald Harrison		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
450.0	Immediate cause	(a) Acute Myocardial Failure	10 Minutes
97	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1949, to 3-7, 1949, that I last saw the deceased alive on 3-5, 1949, and that death occurred at 940 A.m., from the causes and on the date stated above.

SIGNATURE H W Eliason (Degree or title) ADDRESS 26 Union St Cumberland Md DATE SIGNED 3/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF March 9, 1949	NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	LOCATION (City, town, or county) (State) Lonaconing, Md.
DATE REC'D BY LOCAL REG. March 9, 1949	REGISTRAR'S SIGNATURE Winter R. Lantz M.D.	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
MARYLAND
LENGTH OF STAY (in this place): 69 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: McMullen Hwy.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown Md
STREET ADDRESS (If rural give location): McMullen Hwy.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Magdalene	McKenzie	Mar	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	11/18/67	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework		Deer Park Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elijah Hershberger	Minerva Shade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Joseph F. McKenzie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive heart failure	1 year
420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 938	(b) arteriosclerotic heart disease	8 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March 10, 1949, to March 19, 1949, that I last saw the deceased alive on March 18, 1949, and that death occurred at 2:04 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Klinis	MD	59 Greene St. Cumberland Md	3-20-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar 21, 1949	St Ambrose Catholic	Cresaptown	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 21, 1949	[illegible]	John J Hafer	Cumberland Md

RECEIVED
MAR 23 1949
BUREAU V. S.

02240

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 63 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) St Mary's Terrace

3. NAME OF DECEASED (Type or Print) (First) Barbara (Middle) A. (Last) Meyers
4. DATE OF DEATH (Month) March (Day) 13 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Nov 1, 1885
9. AGE last birthday 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Clerk
10b. KIND OF BUSINESS OR INDUSTRY Grocery Store
11. BIRTHPLACE (State or foreign country) Lonaconing, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John C. Meyers
14. MOTHER'S MAIDEN NAME Elizabeth Knaup

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Miss Lizzie Meyers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Anaemia, Coronary disease.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1946, to March, 1949, that I last saw the deceased alive on March 11th, 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE Henry M. Hodgson M.D. (Degree or title) ADDRESS R1 Box 132 DATE SIGNED Cumberland, Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Mar. 16, 1949
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) Lonaconing, Md (State)

DATE REC'D BY LOCAL REG. March 17 1949
REGISTRAR'S SIGNATURE Jannette M Goal
24. FUNERAL DIRECTOR M. Eichhorn, Lonaconing, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12241

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 12 Hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural, give location) Detmold

3. NAME OF DECEASED (Type or Print): (First) Leland (Middle) Oran (Last) Milley

4. DATE OF DEATH: (Month) March (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: March 9-49

9. AGE last birthday: 0 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Lonaconing Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David O. Milley

14. MOTHER'S MAIDEN NAME: Margaret H. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: David O. Milley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
773.5 Immediate cause	(a) Premature Infant — 7 month	
159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pregnancy — only weighed 3 lbs.	12 hrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rt. side of face & Rt. arm was very cyanotic at delivery

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/9, 1949 @ 10 a.m. to 3/9, 1949 @ 1 p.m., that I last saw the deceased alive on 3/9, 1949, and that death occurred at 1 p.m., from the causes and on the date stated above.

SIGNATURE J. E. Berry M.D. (Degree or title) ADDRESS DATE SIGNED March 10-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: March 10, 49; NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery; LOCATION (City, town, or county) (State): Moscow, Md

DATE REC'D BY LOCAL REG. 3-10-49; REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: M. Erickson Lonaconing Md ADDRESS

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02242

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Picardy, Md | LENGTH OF STAY (in this place) 70 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Picardy, Md.
STREET ADDRESS (If rural, give location) near Oldtown, Md.

3. NAME OF DECEASED (Type or Print): [redacted] (First) William D. (Middle) Miller (Last)

4. DATE OF DEATH: (Month) March (Day) I3, (Year) I949

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: Aug. I4, I852 | 9. AGE last birthday: 97 ✓ yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired | 10b. KIND OF BUSINESS OR INDUSTRY: Farmer | 11. BIRTHPLACE (State or foreign country): Barrlesville Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Miller | 14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT: Walter Hall, 703 Va. Ave, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 **Immediate cause** (a) General Arterio-sclerosis — 30.40 yrs?

97 **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause etating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased ~~from~~ on 3-12-49, to ....., 19....., that I last saw the deceased alive on 3-12-49, 19....., and that death occurred at 2:26 a.m. 3-13-49, from the causes and on the date stated above.

SIGNATURE (Degree or title) T. J. Armstrong M.D. ADDRESS Paw Paw W. Va DATE SIGNED 3-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: March I6, 49 | NAME OF CEMETERY OR CREMATORY: Family Cem. Miller | LOCATION (City, town, or county) (State): Picardy, Md.

DATE REC'D BY LOCAL REG.: March 16, 1949 | REGISTRAR'S SIGNATURE: Mrs. Sue C. Grimm | 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 18 1949
BUREAU V. S.

Within corporate limits

mw

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02243

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 12 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland Rural
STREET ADDRESS (If rural give location) R.F.D. #1

3. NAME OF DECEASED (Type or Print) (First) Bernard (Middle) Windell (Last) Moon

4. DATE OF DEATH (Month) March (Day) 20 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Dec. 26 1910

9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Near Oakland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Frederick Moon

14. MOTHER'S MAIDEN NAME Etta M. Sell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 2

16. SOCIAL SECURITY NO. 217-14-4075

17. INFORMANT Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Contusion of brain, hemorrhage slight. edema marked.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Abdominal & pleural*hemorrhage, moderate.

(c) Compound comminuted fracture of both lower legs.

INTERVAL BETWEEN ONSET AND DEATH: about 13 hours

812.5
170 C

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Walking on highway, hit by an automobile.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Laceration, nose & Rt. eyelid

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) auto accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway

(CITY OR TOWN) near Oakland (COUNTY) Garrett (STATE) Md.

TIME OF INJURY (Month) March (Day) 19 (Year) 49 (Hour) about 10 P.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Walking on highway, hit by an auto.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ March 20 1949, ~~to~~ ~~19~~, that I last saw the deceased Dead ~~alive~~ on 3-20, 1949, and that death occurred at 11.30 A.m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED March 20-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Mar. 22, 1949

NAME OF CEMETERY OR CREMATORY Red House Cemetery

LOCATION (City, town, or county) Red House, Maryland (State)

DATE REC'D BY LOCAL REG. March 20, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Emory Bolden Oakland Md ADDRESS

Deputy Medical Examiner - Allegany Co.

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 29 1949
BUREAU V. S.

Within corporate limits DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

12244

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 5 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE PENNSYLVANIA COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NEW PARIS
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) BABY ANNE GIRL (Middle) (Last) MOORE

4. DATE OF DEATH (Month) March (Day) 13 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 3/12/49

9. AGE last birthday ____ yrs. If under 1 year Months ____ Days ____ If under 24 hrs. Hours 5 Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME ROSS SUTER MOORE

14. MOTHER'S MAIDEN NAME ANNA LEE HOLLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH 5 hrs.

769.1 **Immediate cause** (a) Atelectasis, bilateral

161a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Anoxia (Severe diabetic mother).

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 3/12/49

19b. MAJOR FINDINGS OF OPERATION Elective Caesarian - Very large baby

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ____

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY ____ (CITY OR TOWN) ____ (COUNTY) ____ (STATE) ____

TIME OF INJURY (Month) ____ (Day) ____ (Year) ____ (Hour) ____ m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ____

22. I hereby certify that I attended the deceased from 3/12, 1949 to 3/13, 1949, that I last saw the deceased alive on 3/13, 1949, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Royce Hodges, M.D. ADDRESS Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Mar 14 49 | NAME OF CEMETERY OR CREMATORY Schellsburg Pa. | LOCATION (City, town, or county) Schellsburg (State) Pa.

DATE REC'D BY LOCAL REG. March 13, 1949 | REGISTRAR'S SIGNATURE Winter K. Krantz, M.D. | 24. FUNERAL DIRECTOR J. Ralph Mickle ADDRESS Schellsburg Pa.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits

02245

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 29 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 809 Kentucky Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 809 Kentucky Ave.

3. NAME OF DECEASED (Type or Print) (First) Calvin (Middle) (Last) Morris

4. DATE OF DEATH (Month) March (Day) 28 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH Feb. 20-1868
9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman
10b. KIND OF BUSINESS OR INDUSTRY Own business
11. BIRTHPLACE (State or foreign country) Bedford Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Israel Morris
14. MOTHER'S MAIDEN NAME Julia Hemming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Hazel Lipscomb

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Apoplexy	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertention due to arteriosclerosis	?
	(c)	

334
830

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

Deputy Medical Examiner - Allegany Co.

22. I hereby certify that I ~~attended~~ Saw the deceased ~~from~~ Mar. 28, 1949 to ~~-------, 19--~~, that I last saw the deceased Dead ~~alive~~ on March 28, 1949 and that death occurred at 9.35 A.m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED March 28- 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Mar. 30, 1949
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) Parsons W.Va. (State)

DATE REC'D BY LOCAL REG. March 30, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz M.D.
24. FUNERAL DIRECTOR John J. Hofer, ADDRESS Cumberland, Md.

Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
APR 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02246

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
LENGTH OF STAY (In this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN McCoole
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Edward (Last) Morris
4. DATE OF DEATH (Month) March (Day) 12, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 6, 1875
9. AGE last birthday 73 yrs. If under 1 year Months 8 Days 8 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector
10b. KIND OF BUSINESS OR INDUSTRY B.&O. R.R.Co.
11. BIRTHPLACE (State or foreign country) Grant Co., W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James Thomas Morris
14. MOTHER'S MAIDEN NAME Rachael Mugglain Rohrbough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT James Morris Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Arteriosclerosis

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 13, 1946, to Mar. 7, 1949, that I last saw the deceased alive on Mar. 7, 1949, and that death occurred at 8:35 P.M. m., from the causes and on the date stated above.

SIGNATURE Wm. A. Flick, M.D. (Degree or title) ADDRESS Keyser, W. Va. DATE SIGNED Mar. 14, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 3-15-49
NAME OF CEMETERY OR CREMATORY Dayton Cemetery
LOCATION (City, town, or county) (State) 21st. Bridge, Allegany Co., Md.

DATE REC'D BY LOCAL REG. Mar. 15, 1949
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR Rogers Funeral Home, ADDRESS Keyser, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
MAR 16 1949
BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

012247

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 44 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 514 Rose Hill Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 514 Rose Hill Ave

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) (Last) Nesbitt

4. DATE OF DEATH: (Month) March (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 20 1864

9. AGE last birthday: 84 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Westernport Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Noel Pearce

14. MOTHER'S MAIDEN NAME: Sarah Onion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. Edward W. Dawson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0 **Immediate cause** (a) Arteriosclerosis

97 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obstructive Jaundice

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 3, 19 34, to 3-22-49, 19 49, that I last saw the deceased alive on 3-22-49 19, and that death occurred at 12:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Charlotte B Gardner — ADDRESS — DATE SIGNED: March 22, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Mar 24 1949 | NAME OF CEMETERY OR CREMATORY: Philos Cemetery | LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: March 23, 1949 | REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

RECEIVED
MAR 29 1949
BUREAU V. S.

Within corporate limits

02248

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 50 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Co Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 757 Maryland Ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Susan E. Niceley

4. DATE OF DEATH (Month) (Day) (Year): March 4 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 10 1865
9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Rosendale Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob R Roades
14. MOTHER'S MAIDEN NAME: Jane Hopcraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Jesse Hopcraft

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cerebral Vascular Accident — 20 hrs

83a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

II (c) Atrophic Arthritis knees + ankles — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1946, to Mar. 4, 1949, that I last saw the deceased alive on Mar. 3, 1949, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones M.D. (Degree or title) — ADDRESS: 110 S. Centre St. Cumberland — DATE SIGNED: Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Mar. 7 '49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: March 7, 1949 — REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

02249

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Old Town
LENGTH OF STAY (in this place) 16 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS One Mile West

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) One Mile West

3. NAME OF DECEASED (Type or Print) (First) Lillie (Middle) Amelia (Last) Rawlings

4. DATE OF DEATH (Month) March (Day) 31, (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 2-28-1872
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Westernport, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles Whitmyer
14. MOTHER'S MAIDEN NAME Laura Tice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Herman Rawlings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intra Cerebral Hemorrhage	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 yrs +.
	(c)	

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1949, to 3-30-, 1949, that I last saw the deceased alive on 3-30-, 1949, and that death occurred at 5 a. m., from the causes and on the date stated above.

SIGNATURE J. T. Armstrong (Degree or title) M.D. ADDRESS Pair Pair, W. Va DATE SIGNED 4-2-49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-3-1949
NAME OF CEMETERY OR CREMATORY Porter Cem.
LOCATION (City, town, or county) (State) Eckhart, Md.

DATE REC'D BY LOCAL REG. April 2, 1949
REGISTRAR'S SIGNATURE Mrs. Sue C. Gineman
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

4/5/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 7 1949
BUREAU T. S.

Within corporate limits? DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02250

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully: The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, | LENGTH OF STAY (In this place) 2 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA — COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG, W.VA.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) BABY (Middle) BOY (Last) RIGGLEMAN - Twin #1

4. DATE OF DEATH: (Month) MARCH (Day) 22 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 3/22/49

9. AGE last birthday: yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours 2 | Min 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: PATTY RIGGLEMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity (6 mo)

776 159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 3:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Euler B Whitworth

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Mar. 23, 1949	Petersburg W. Va.	Petersburg, West Virginia	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 22, 1949	Winter R. Lantz, M.D.	P. E. Thrush and Son	Petersburg, W. Va.

VS. A15

RECEIVED
MAR 29 1949
BUREAU V. S.

DR. WHITWORTH

Within corporate limits

02251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 1 HOUR	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY (Last) RIGGLEMAN - Twin #2			4. DATE OF DEATH (Month) MARCH (Day) 22 (Year) 1949		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH MARCH 22, 49	9. AGE last birthday yrs.	If under 1 year Months / Days; If under 24 hrs. Hours 1 / Min. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY USA.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME PATTY RIGGLEMAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.		17. INFORMANT MEMORIAL HOSPITAL		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity (6 mo)

776 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

159

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:55 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Fuller B. Whitworth

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar. 23, 1949	NAME OF CEMETERY OR CREMATORY Petersburg Cemetery	LOCATION (City, town, or county) (State) Petersburg, West Virginia
DATE REC'D BY LOCAL REG. March 22, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR P.E. Thrush and Son, Petersburg, W. Va.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 29 1949
BUREAU P. S.

Within corporate limits

Hodg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02252

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 49 Humbird St.

3. NAME OF DECEASED (Type or Print): (First) Mollie (Middle) Mae (Last) Robinette

4. DATE OF DEATH: (Month) Mar (Day) 11 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 22, 1916

9. AGE last birthday: 32 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector of yarn

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp

11. BIRTHPLACE (State or foreign country): Allegany Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael E. McCabe

14. MOTHER'S MAIDEN NAME: Effie Hartman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-2340

17. INFORMANT: Homer Robinette

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

641 **Immediate cause** (a) Peritonitis — Interval between onset and death: 6 Day

1476 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Meckel's diverticulitis — 1 day

(c) Pregnancy - 1 day postpartum — 9 mon.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: March 7 '49

19b. MAJOR FINDINGS OF OPERATION: Pelvic peritonitis

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN): — (COUNTY): — (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 19 48, to Mar. 11, 19 49; that I last saw the deceased alive on Mar. 11, 19 49, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W R Royce Hodges M.D. — ADDRESS Cumberland, Md. — DATE SIGNED 3/12/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: March 13, 1949 — NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: March 13, 1949 — REGISTRAR'S SIGNATURE: Winter R. Beauty, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hofer, Cumberland, Md.

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02253

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Union Street

3. NAME OF DECEASED (Type or Print) (First) Etta (Middle) W. (Last) Savage

4. DATE OF DEATH (Month) (Day) (Year) March 7 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug 17 1877
9. AGE last birthday 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Coleman
14. MOTHER'S MAIDEN NAME Martha Davison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT Mrs. Chas. Beaman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Vascular Accident	2 wks
830	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	5 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 14, 1948, to Mar. 7, 1949, that I last saw the deceased alive on Mar. 5, 1949, and that death occurred at 12 30 p.m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones M.D. (Degree or title) 110 S. Centre St. ADDRESS Cumberland Md DATE SIGNED Mar. 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE March 11, 1949
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) Lonaconing Allegany Co. Md (State)

DATE REC'D BY LOCAL REG. March 11, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz M.D.
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

(Corrected)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02254

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: W.Va. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Luke — LENGTH OF STAY (in this place): 28 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Piedmont
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Luke Paper Mill	STREET ADDRESS (If rural, give location): 37 Orchard St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): John Serpone			4. DATE OF DEATH (Month) (Day) (Year): March 8 1949		
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: 3-15-1897	9. AGE last birthday: 51 yrs.	If under 1 year: Months 11, Days 23; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill		11. BIRTHPLACE (State or foreign country): Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Nico Ta Serpone			14. MOTHER'S MAIDEN NAME: Lucia Tronla		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)		16. SOCIAL SECURITY No.: 217-05-0994	17. INFORMANT: Joseph Serpone (Son)		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carbon monoxide — ?

892.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Shoveling down coal, for boiler, building inclosed

178C

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary occlusion & coronary sclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Luke Paper Mill	(CITY OR TOWN): Luke	(COUNTY): Allegany	(STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 3-8-49 about 1 P. m.	INJURY OCCURRED While at Work * Not While At work ☐	HOW DID INJURY OCCUR? Shoveling down coal, for boiler, building inclosed.		

Deputy Medical Examiner

22. I hereby certify that I ~~attended~~ saw the deceased from 3-8-, 1949, to ----------, 19---, that I last saw the deceased ~~alive~~ Dead on 3-8-, 1949, and that death occurred at about 1 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D.	H. V. Deming M.D.	Cumberland Md.	3-8-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 3-12-49	NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery	LOCATION (City, town, or county) (State): Westernport Allegany Md.
DATE REC'D BY LOCAL REG.: March 11, 1949	REGISTRAR'S SIGNATURE: A. J. Fagenbaker, per T.	24. FUNERAL DIRECTOR: E.S.Boals	ADDRESS

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MAR 30 1949

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02255

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 3 WKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna. COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman
STREET ADDRESS (If rurel, give location)

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) C. (Last) Shaffer

4. DATE OF DEATH: (Month) March (Dey) 8 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. ? 1877

9. AGE last birthday: 72 yrs. | If under 1 year: Months. Deys | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Emerick

14. MOTHER'S MAIDEN NAME: Emira McChune

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give wer or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Ralph Fisher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 **Immediate cause** (a) Chronic Hypertension Arterio-Sclerotic Heart Disease — Interval Between Onset and Death: 10 yrs.

Antecedent cause(s)

938 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not releted to the disease or condition ceusing death. Chronic Biliary Tract Disease with cholelithiasis — 8 yrs.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Yeer) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19.38, to Mar 8, 19.49, that I last saw the deceased alive on 3/8, 1949, and that death occurred at 8.30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Topper MD — ADDRESS Hyndman Pa — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 11, 1949	Madley	Bedford Co., Penna.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 10, 1949	Winter R. Frantz, M.D.	Harvey H. Zeigler	Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02256

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 90 M.H. Pleasant

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Annie Lucilla Stirner

4. DATE OF DEATH (Month) (Day) (Year): March 7, 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Mar. 25-1864
9. AGE last birthday: 84 yrs. — If under 1 year: Months. # Days 13 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? N. S.

13. FATHER'S NAME: Peter E. Pressman
14. MOTHER'S MAIDEN NAME: Rachel J. Stott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Allegany County Infirmary

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Post pharyngeal abscess Septicemia — 10 days

517 Antecedent cause(s)

115C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Mar 7, 1949, that I last saw the deceased alive on Mar 5, 1949, and that death occurred at 12 45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur F. Jones M.D. 110 S. Centre St. Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 3-9-1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: March 9, 1949 — REGISTRAR'S SIGNATURE: Winter R. Wantz, M.D. — 24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02257

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 66 Aspinall St.

3. NAME OF DECEASED (Type or Print) (First) Larry (Middle) Leroy (Last) Skidmore

4. DATE OF DEATH (Month) 3 (Day) 5 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 2-10-49

9. AGE last birthday yrs. If under 1 year: Months 3wks. Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md., Allegany

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Leroy E. Skidmore

14. MOTHER'S MAIDEN NAME Esther R. Cavey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Leroy Skidmore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

763.0 Immediate cause (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days.

107 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4, 1949, to 3/5, 1949, that I last saw the deceased alive on 3/4, 1949, and that death occurred at 4:25 A m., from the causes and on the date stated above.

SIGNATURE A. Gattens (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 3/5/49

Burial Allegany Frostburg Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 3-6-1949

NAME OF CEMETERY OR CREMATORY Allegany Cemetery

LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 3-7-49

REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 10 1949
BUREAU T. S.

Dr. P.E. Berry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02258

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Luke
LENGTH OF STAY (in this place): 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 236 Cromwell St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Luke
STREET ADDRESS (If rural, give location): 236 Cromwell St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Rebecca (Last) Smith

4. DATE OF DEATH: (Month) March (Day) 20 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: June 12, 1877

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own-Home

11. BIRTHPLACE (State or foreign country): Rockingham Co. Va.

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: Cornealis Whetzel

14. MOTHER'S MAIDEN NAME: Betsy Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): XXXX
(If year, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.: XXXXX

17. INFORMANT: Loy Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetes Mellitus

260 Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetic Ulcer

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1944, to March 20 1949, that I last saw the deceased alive on March 20, 1949, and that death occurred at 950a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

P.E. Berry M.D. Piedmont W Va 3/20/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: March 22, 1949

NAME OF CEMETERY OR CREMATORY: Philos

LOCATION (City, town, or county) (State): Westernport, Md

DATE REC'D BY LOCAL REG. Mar. 27/49

REGISTRAR'S SIGNATURE: Kaylor Baker Mc

24. FUNERAL DIRECTOR: Ellsworth S. Boal

ADDRESS: Westernport, Md.

VS. A15

RECEIVED
MAR 23 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 406 Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 406 Virginia Ave

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Franklin (Last) Smith

4. DATE OF DEATH: (Month) Mar. (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Oct. 24, 1877

9. AGE last birthday: 71 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineering

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Smith

14. MOTHER'S MAIDEN NAME: Louisa Haugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No. VVO-10-8926

17. INFORMANT: Miss Annie Smith, Union Bridge, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	3 hrs.
260 Antecedent cause(s)		
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	1 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1948 to Mar. 5 1949, that I last saw the deceased alive on Mar. 5, 1949, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE: Clark Durrett (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: 3/5/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Mar. 8, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery — LOCATION (City, town, or county) (State): Union Bridge, Maryland

DATE REC'D BY LOCAL REG.: March 6, 1949 — REGISTRAR'S SIGNATURE: Walter K. Mantz, M.D.

24. FUNERAL DIRECTOR: Hartzler and Son — ADDRESS: Union Bridge, Md.

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02260

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Morantown; LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Morantown; STREET ADDRESS (If rural give location): R.F.D.2 Box 36 Frostburg Md

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louis		Spartaro	March	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	3-15-1880	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
miner	mining coal	Italy	U.S.A.

13. FATHER'S NAME: Frank Spartaro

14. MOTHER'S MAIDEN NAME: Genevieve Arnoni

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: 182-01-4168

17. INFORMANT: Mrs. Frances Lynch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 61

Immediate cause (a) Diabetes Mellitus — Interval between onset and death: 6 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from 3-7-, 1949, to ---------, 19..., that I last saw the deceased alive on 3-7-, 1949, and that death occurred at about 7 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D	H. V. Deming M.D.	Cumberland Md.	3-8-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-10-49	St. Michael's Cemtery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-9-49	Mrs. Nancy H. Ross	J. R. Durst,	Frostburg, Md.

Deputy Medical Examiner - Allegany Co

RECEIVED
MAR 14 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02261

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Pennslvania COUNTY: Fulton
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 24 hours	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Amaranth
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural give location): ✓

3. NAME OF DECEASED (Type or Print)	(First) Lewis	(Middle) Franklin	(Last) Stahle	4. DATE OF DEATH	(Month) March	(Day) 19	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Nov 16 1887	9. AGE last birthday: 61 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher	10b. KIND OF BUSINESS OR INDUSTRY: Teaching	11. BIRTHPLACE (State or foreign country): Amaranth, Fulton Co, Pa	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: John Stahle	14. MOTHER'S MAIDEN NAME: Sarah Bischop						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Mrs Martha Garland Stahle					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
463 Immediate cause	(a) Pulmonary embolism, massive	Immediate
100 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Thrombo-phlebitis, septic, lower extremity right, extending to inferior vena cava	March 5, 1949
	(c) *(over)	14 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Just after anesthesia was started - fatal embolism occurred.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: * Prepared for operation for legative inferior vena cava	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 19, 1949, to Mar 19, 1949, that I last saw the deceased alive on Mar 19, 1949, and that death occurred at 3:05 pm m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wyhe M Haw Jr	Md	Cumberland Md	Mar 20, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Mar 23 1949	NAME OF CEMETERY OR CREMATORY: Buck Valley Methodist Cem	LOCATION (City, town, or county) (State): Amaranth, Fulton Co, Pa
DATE REC'D BY LOCAL REG.: March 21, 1949	REGISTRAR'S SIGNATURE: Winter K. Frantz, M.D.	24. FUNERAL DIRECTOR: Charles R. Bast	ADDRESS: Hancock, Md.

Patient was prepared for ligation inferior Vena Cava. Just after anesthesia was started - fatal embolism occured

wms Jr.

RECEIVED
MAR 29 1949
BUREAU V. S.

Within corporate limits

DR HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02262

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 8 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: PA — COUNTY: BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BREEZEWOOD
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) MARSHALL (Middle) N (Last) STAILY

4. DATE OF DEATH: (Month) MARCH (Day) 8 (Year) 1949

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: OCT. [redacted] 1872 — 9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JUSTICE OF THE PEACE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Breezewood, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM A [redacted]Y Staily
14. MOTHER'S MAIDEN NAME: MARTHA J. RINARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY No.: None
17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

153 **Immediate cause** (a) Cerebral hemorrhage, left, ruptured — Paralysis — 36 hours

46e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Hepatic Flexure Colon — Excision Hepatic Flex. Colon, Right side of Abd. Wall — 6 days

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. We think the situation was not related and perhaps a cause of Cerebral Hemorrhage

19a. DATE OF OPERATION: 3-2-49 — 19b. MAJOR FINDINGS OF OPERATION: above — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/26, 1949, to 3-8, 1949, that I last saw the deceased alive on 3/7, 1949, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE AND (Degree or title): C H Hawkins — ADDRESS: Cumberland Md. — DATE SIGNED: 3-8-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: March 11, 1949 — NAME OF CEMETERY OR CREMATORY: Mt. Zion Lutheran Cem — LOCATION (City, town, or county) (State): Breezewood, Penna.

DATE REC'D BY LOCAL REG.: March 8, 1949 — REGISTRAR'S SIGNATURE: Walter L. Frantz, M.D. — 24. FUNERAL DIRECTOR AND ADDRESS: Richard K. Shoemaker, Everett, Penna.

RECEIVED
MAR 15 1949
BUREAU V. S.

Within corporate limits: DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02263

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (In this place): 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: ~~KEYSER~~ W. VA. COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KEYSER Ft. Ashby
STREET ADDRESS (If rural give location): RT. #2

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) Cook (Last) STALLINGS

4. DATE OF DEATH: (Month) MARCH (Day) 13 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAY 30 1886

9. AGE last birthday: 62 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traffick Clerk

10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LESLIE STALLINGS

14. MOTHER'S MAIDEN NAME: ELIZABETH COOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-14-1684

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 / 131 b

		Interval Between Onset and Death
Immediate cause	(a) Uraemia	2 wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	2 yrs.
	(c) Chronic Nephritis	2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 1, 1949, to Mar. 13, 1949, that I last saw the deceased alive on Mar. 13, 1949, and that death occurred at 6:35 P.M., from the causes and on the date stated above.

SIGNATURE: Clayt Durrett (Degree or title) M.D. ADDRESS: Cumberland DATE SIGNED: Mar. 14, 1949.

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF: Mar. 17 49

NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: March 15, 1949

REGISTRAR'S SIGNATURE: Walter L. Krantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein, Inc. ADDRESS: Cumberland, Md.

MAR 22 1949

Within corporate limits

Rozum

02264

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Old Town
STREET ADDRESS (If rural, give location) R.D.# 1.

3. NAME OF DECEASED (Type or Print) (First) Marshall (Middle) A. (Last) Stallings
4. DATE OF DEATH (Month) Mar. (Day) 28, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 2-15-1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Old Town, Md.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Tolbert Stallings
14. MOTHER'S MAIDEN NAME Elizabeth Stallings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. James Stallings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of cecum & ascending colon	—
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) —	
	(c) —	

153

46 e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION Resection
19b. MAJOR FINDINGS OF OPERATION Carcinoma of colon
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) ~~SUICIDE~~ HOMICIDE
PLACE (Home, farm, factory, street, ~~office bldg., etc.~~) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURRED While at Work ☐ ~~Not While~~ At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1949, to 3/28, 1949, that I last saw the deceased alive on 3/28, 1949 and that death occurred at 8 m., from the causes and on the date stated above.

SIGNATURE John K. Rozum (Degree or title) MD ADDRESS Cumberland Md DATE SIGNED 3/31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 3-31-1949
NAME OF CEMETERY OR CREMATORY Mt. Olive
LOCATION (City, town, or county) (State) Old Town, Md.

DATE REC'D BY LOCAL REG. March 31, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02265

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital 3.1/2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 200 Glenn St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) F. (Last) Stapleton

4. DATE OF DEATH: (Month) March (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: March 30-1866

9. AGE last birthday: 82 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): La Vale, near Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Orman H. Frost

14. MOTHER'S MAIDEN NAME: Margaret W. Lodgston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: J.T. Defibaugh

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shock, due to crushed chest, right pelvis — 4 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) retro-peritoneal hemorrhage, subcutanious emphysemia, fracture of right clavicle and

(c) maxillary, atelectasis of both lungs.

802.5
169

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE: accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: B&O. Ry (CITY OR TOWN): Baltimore St Cumberland (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) March (Day) 16 (Year) 49 (Hour) 1.30 P. m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Hit by a B&O passenger engine.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Dead 3-16, 1949, ~~to~~, ~~19~~, that I last saw the deceased ~~alive~~ Dead on 3-16, 1949, and that death occurred at 5.25 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.V. Deming M.D. — H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: March 16- 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: March 19, 1949 — NAME OF CEMETERY OR CREMATORY: St Micheals Cemetery — LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE RECD BY LOCAL REG.: March 18, 1949 — REGISTRAR'S SIGNATURE: Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

Deputy Medical Examiner - Allegany Co.

VS. A15

RECEIVED
MAR 22 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02266

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE West Virginia COUNTY Tucker
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davis
STREET ADDRESS (If rural, give location) William Ave.

3. NAME OF DECEASED (Type or Print) (First) marian (Middle) (Last) Straw

4. DATE OF DEATH (Month) Mar. (Day) 8 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Apr. 17, 1916

9. AGE last birthday 32 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superviser

10b. KIND OF BUSINESS OR INDUSTRY Celenese Plant

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME malone Gayner

14. MOTHER'S MAIDEN NAME Annie Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-5484

17. INFORMANT Annie Gayner (mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Addison's Disease — Interval between onset and death: 1-2 years

274 Antecedent cause(s)

650 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1941, to March 8, 1949, that I last saw the deceased alive on March 8, 1949, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) B. M. Schneider MD ADDRESS 41 Greene St Cumberland, Md DATE SIGNED March 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE mar. 11, 1949

NAME OF CEMETERY OR CREMATORY Davis City Cemetery

LOCATION (City, town, or county) (State) Davis, Tucker Co. W. Va.

DATE REC'D BY LOCAL REG. March 10, 1949

REGISTRAR'S SIGNATURE Winter K. Kautz M.D.

24. FUNERAL DIRECTOR Wayne E. Spiggle ADDRESS Davis, Pt. Va.

VS. A15

RECEIVED
MAR 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02267

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rawlings | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rawlings
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Alda (Middle) Elizabeth (Last) Suder

4. DATE OF DEATH: (Month) March (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 15, 1878

9. AGE last birthday: 70 yrs. | If under 1 year: Months 5 Days 28 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Herman H. Suder

14. MOTHER'S MAIDEN NAME: Matilda Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	1 Min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	6 Months
	(c)	

420.1
938

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1949, to Mar. 13, 1949, that I last saw the deceased alive on....., 19....., and that death occurred at 6 00P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Wm F McFarland | Cresaptown, Md. | Mar. 13-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 3-16-49 | NAME OF CEMETERY OR CREMATORY: Biertown Cemetery | LOCATION (City, town, or county): Rawlings | (State): Md.

DATE REC'D BY LOCAL REG.: 3/16/49 | REGISTRAR'S SIGNATURE: M. S. Summers

24. FUNERAL DIRECTOR: Rogers Funeral Home | ADDRESS: Keyser, W. Va.

VS-A15

RECEIVED
MAR 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02268

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) Lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS 30 Stiger St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 30 Stiger St

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Estelle (Last) Thompson

4. DATE OF DEATH: (Month) 3 (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 3-5-1877

9. AGE last birthday: 72 yrs. If under 1 year: Months. 0 Days 8 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Samuel Lewis

14. MOTHER'S MAIDEN NAME: Ruth Ebaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Bray Thompson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis -

420.1 Antecedent cause(s)

940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis

(c) Pleurisy -

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-7, 1949, to 3-13, 1949, that I last saw the deceased alive on 3-13, 1949, and that death occurred at 11:45A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John B. Davis, MD Frostburg, Md 3-14-49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE 3-16-1949; NAME OF CEMETERY OR CREMATORY Allegany Cemetery; LOCATION (City, town, or county) Frostburg (State) Md.

DATE REC'D BY LOCAL REG. 3-14-49; REGISTRAR'S SIGNATURE Mrs. Hallie K. Roe; 24. FUNERAL DIRECTOR Jacob Harper; ADDRESS Frostburg Md.

RECEIVED
MAR 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02269

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Dawson — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kitzmiller
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ambulance enroute to Memorial Hospital	STREET ADDRESS (If rural, give location) Hill Street

3. NAME OF DECEASED (Type or Print) (First) Grover (Middle) Cleveland (Last) Tranum, Sr.			4. DATE OF DEATH (Month) March (Day) 18, (Year) 1949		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 29, 1888	9. AGE last birthday 60 yrs.	If under 1 year Months 9 Days 19 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	11. BIRTHPLACE (State or foreign country) Franklin, Alleg.Co., Md.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Jefferson Tranum		14. MOTHER'S MAIDEN NAME Kathern McManis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 213-01-6608	17. INFORMANT Charles Tranum-Kitzmiller, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bilateral Broncho-Pneumonia	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Influenza	5 days
	(c) Chronic Bronchial Asthma	?

480
33 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1942, to March 18, 1949, that I last saw the deceased alive on March 18, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Ralph Colandella	M.D.	Kitzmiller Md	March 19-49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar.21/49	NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	LOCATION (City, town, or county) (State) Elk Garden, W.Va.
DATE REC'D BY LOCAL REG. Mar 20/49	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Otha F. Sharpless- Blaine, W.Va.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
MAR 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

(12270)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Bonnie (Middle) Sue (Last) Warnick

4. DATE OF DEATH: (Month) March (Day) 2 (Year) 1949

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Child — 8. DATE OF BIRTH: Sept. 3, 1948 — 9. AGE last birthday: - yrs. — If under 1 year: Months 5 Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None — 10b. KIND OF BUSINESS OR INDUSTRY: None — 11. BIRTHPLACE (State or foreign country): Maryland Allegany Co. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Ernest Warnick — 14. MOTHER'S MAIDEN NAME: Viola Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No — 16. SOCIAL SECURITY No.: none — 17. INFORMANT: Harry Warnick Lonaconing, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchial Pneumonia — 4 da.

491 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

107 (c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: None — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/28/ ....., 1949, to 3/2 ....., 1949, that I last saw the deceased alive on 3/1 ....., 1949, and that death occurred at 1:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Paul Eugene Frye, M.D. — Lonaconing Md. — 3/3/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: March 4 1949 — NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery — LOCATION (City, town, or county) (State): Moscow, Md

DATE REC'D BY LOCAL REG. 3-4-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Rose — 24. FUNERAL DIRECTOR — ADDRESS: M. Eichhorn Lonaconing, Md

RECEIVED
MAR 8 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02271

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 6hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) W (Last) Wilgar
4. DATE OF DEATH: (Month) 3 (Day) 27 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 7/26/1894
9. AGE last birthday: 54 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Painter
11. BIRTHPLACE (State or foreign country): Ellerslie Md.
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Lemuel F Wilgar
14. MOTHER'S MAIDEN NAME: Sophia Jane Smouse
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Minnie G. Fuller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocardosis — 6 yrs.

420.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial Infarction. — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1938, to Mar 27, 1949, that I last saw the deceased alive on 3/27, 1949, and that death occurred at 10.10pm., from the causes and on the date stated above.

SIGNATURE: John A Topper (Degree or title) MD — ADDRESS: Hyndman Pa — DATE SIGNED: 3/28/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 3/30/49
NAME OF CEMETERY OR CREMATORY: Hillcrest
LOCATION (City, town, or county): Cumberland (State) Md.

DATE REC'D BY LOCAL REG.: March 30, 1949
REGISTRAR'S SIGNATURE: Winter R. Krantz M.D.
24. FUNERAL DIRECTOR: Harvey H. Tugler — ADDRESS: Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1949
BUREAU V. S.

02272

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport — LENGTH OF STAY (in this place): 57 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 129 Wood St.	STREET ADDRESS (If rural, give location): 129 Wood St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): FLORIAN ANDREW WILSON	4. DATE OF DEATH (Month) (Day) (Year): March 26 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
Male	White	Married	June 3, 1891	57 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Constable		Maryland	America

13. FATHER'S NAME: Jacob Wilson	14. MOTHER'S MAIDEN NAME: Mary Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXXX (If year, give war or dates of service) XXXX	16. SOCIAL SECURITY No.
17. INFORMANT: Mrs. Flora A. Wilson	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	4 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive cardio-vascular disease	10 yrs
	(c)	

443
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to March 26, 1949, that I last saw the deceased alive on March 26, 1949, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H Wolverton Jr	MD	Piedmont	March 27, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March, 29, 49	Philos	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 29/49	[illegible] MD	Ellsworth S. Boal	Westernport, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 30 1949
BUREAU F. S.

Within corporate limits

RR Unit WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02273

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD — COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER
STREET ADDRESS (If rural give location)

(11:00A.M.)

3. NAME OF DECEASED (Type or Print): (First) ALLEN (Middle) B. (Last) WOLFE

4. DATE OF DEATH: (Month) MARCH (Day) 18 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAY 3, 1901

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES M. WOLFE

14. MOTHER'S MAIDEN NAME: WHITEHAIR, MARY V.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II

16. SOCIAL SECURITY NO. 236-12-5687

17. INFORMANT: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151 Immediate cause (a) Acute Cardiac dilitation — 5 min

46 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adeno Carcinoma Stomach — ?

(c) Gastric resection

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 3-18-49 — 19b. MAJOR FINDINGS OF OPERATION: Adeno Carcinoma Stomach — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 15 19.49, to March 18 19.49, that I last saw the deceased alive on 3-18 19.49, and that death occurred at 2:15 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

3-18-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Mar 21/49 — NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery — LOCATION (City, town, or county) (State): Elk Garden W Va

DATE REC'D BY LOCAL REG.: March 21, 1949 — REGISTRAR'S SIGNATURE: Winter K. Sauls, M.D. — 24. FUNERAL DIRECTOR: O. F. Shaffer — ADDRESS: Blaine W Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02274

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 10 wks.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania; COUNTY Bedford; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman; STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Louise (Middle) Alice (Last) Wood

4. DATE OF DEATH: (Month) March (Day) 10, (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 12, 1871

9. AGE last birthday: 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick S. Weller

14. MOTHER'S MAIDEN NAME: Mary Ann Hammer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Weller E. Wood

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Chronic Arteriosclerotic Heart Disease — 10 yrs.

100b **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Amputation left leg above knee for Thrombosed Femoral vein after surg. — 2 wks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Clot in ascending & descending trunk.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Mch 10, 1949, that I last saw the deceased alive on Mar 10, 1949, and that death occurred at 3 0 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Topper — Hyndman Pa.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE 3/14/49 — NAME OF CEMETERY OR CREMATORY: Hyndman — LOCATION (City, town, or county) (State): Hyndman Penna.

DATE REC'D BY LOCAL REG. March 12, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Pa.

RECEIVED
MAR 15 1949
BUREAU V. S.